PART 1.

MEDICAL BOARD OF CALIFORNIA

BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM

BACKGROUND AND DESCRIPTION OF THE BOARD AND PROFESSION

History of the Medical Board and Regulation of Physicians and Other Health Professions

In 1876, conflicts between various groups of health care practitioners led the Legislature, at the request of the California State Medical Society (predecessor to the California Medical Association) to enact the first Medical Practice Act (Act) in California. According to the Medical Board's sunset report, the members of the State Medical Society were concerned about the proliferation of quacks and charlatans, and the growing influence of other systems of medical theory including homeopathy, osteopathy, naturopathy and chiropractic. The board's report goes on to say that the initial motivation was to restrict medical licensure to practitioners of allopathic medicine, and to assure that only qualified individuals would be permitted to practice medicine.

In 1907, the Act was amended and included three types of certificates: (1) medicine and surgery, (2) osteopathy, and (3) other modes of healing. The latter in 1909 included specified individuals certified as naturopaths. At one time the board's membership included allopathic physicians, homeopaths, osteopaths, and eclectic medicine practitioners. In 1913 the osteopathic and naturopathic certification was repealed, and drugless practitioners were added. The board was referred to at that time as the Board of Medical Examiners. In 1922 a separate licensing board was created by Initiative for osteopaths. In 1937, the Act was amended and also authorized the practice of Chiropody (now Podiatry regulated by the Board of Podiatric Medicine) and midwifery. In 1949 the “drugless practitioner” classification was eliminated (“closed” - leaving only existing practitioners licensed.) As a result, the Medical Board began to issue just one type of medical license - for physicians and surgeons - with an unlimited ("plenary") scope of practice.

In 1975 the passage of the Medical Injury Compensation and Reform Act (MICRA) enacted limitations on civil actions regarding medical malpractice cases. That law also sought to enhance the board's ability to discipline incompetent physicians by increasing the board's size, public membership, and changing its name to the Board of Medical Quality Assurance (BMQA). The name was changed again in 1990 to the Medical Board of California. The Medical Practice Act is found at B&P Code Sections 2000 et seq., with related regulations found in Title 16, California Code of Regulations,(CCR) Sections 1300 et seq.

The former licensure of midwives by the board was repealed in 1994, and replaced with new licensure provisions that same year. Those provisions (B&P Code Sections 2505 et seq.)

were intended to provide a licensure alternative for midwives who were not trained or licensed as nurses (and who subsequently may become licensed as nurse-midwives) but who had similar training as nurse midwives in midwifery practice. The first licensed midwives in that program were licensed in September of 1995 through reciprocity with the State of Washington. Licensed midwives may, under the supervision of a licensed physician, attend cases of normal childbirth and provide prenatal, intrapartum, and postpartum care, including family-planning care for the mother and immediate care for the newborn. There are approximately 40 licensed midwives currently.

Registered dispensing opticians (RDOs) are individuals or companies in the business of filling prescriptions for spectacle or contact lenses prescribed by a physician or optometrist. Pursuant to B&P Code Sections 2550 et seq. and 16 CCR Sections 1399.200 et seq., RDO's are registered with the board, and RDO registration was established in 1939 by the Legislature. Currently there are approximately 1400 RDOs. No one may fit spectacle lenses unless he or she is registered as a Spectacle Lens Dispenser (SLD) or is under the direct responsibility of an SLD. SLD's have been registered by the board since 1988, and currently there are approximately 2271 SLDs. Similarly, no one may fit contact lenses unless he or she is registered as a Contact Lens Dispenser or CLD or is under a CLD's direct responsibility and supervision. CLDs have been registered by the board since 1983, and currently there are about 584 CLDs.

Research Psychoanalysts (RPs) (B&P Code Sections 2529 & 2530 , and 16 CCR Sections 1367 et seq.) have been registered by the board since 1978. A RP is an individual who is a graduates of an approved psychoanalytic institute who engages in psychoanalysis as an adjunct to teaching, training or research and who hold himself or herself out as a psychoanalyst, or a RP is a person who is a student in a psychoanalytic institute who engages in psychoanalysis under supervision. Currently there are about 69 RPs.

Medical assistants (B&P Code Sections 2069 & 2071, and 16 CCR Sections 1366 et seq.) are unlicensed persons who may perform basic administrative, clerical and “technical supportive services” for physicians and podiatrists, and who have the minimum hours of appropriate training pursuant to standards established by the board's Division of Licensing. Medical assistants are registered with the board.

Drugless practitioner (B&P Code Sections 2500 et seq.) is a license classification that was closed in 1949, though persons who held a license as such at that time were permitted to renew them thereafter. Drugless practitioners may treat diseases, injuries, deformities or other physical or mental conditions without the use of drugs or medical preparations, and without severing or penetrating any tissues of a human being except for severing of the umbilical cord. No information was provided regarding whether there are still any remaining drugless practitioners licensed by the board.

Board composition

The board is composed of 19 members: 12 physicians and 7 public members. The Governor appoints the 12 physician and 5 of the public members, with the Senate Rules Committee and the Speaker of the Assembly each appointing one of the two remaining public members. Board members are each appointed for a term of four years. The board is divided into two separate divisions: the Division of Licensing (DOL) made up of seven members (four physician and three public members) and the Division of Medical Quality (DMQ) made up of

12 members (eight physician and four public members). The DMQ is responsible for the administration of the board's disciplinary enforcement system and, for purposes of adjudicating disciplinary matters, is divided into two separate disciplinary panels each made up of four physician and two public members.

Regulation and Scope of Practice of Board Licensees

The board directly licenses and/or regulates over 104,000 "physicians and surgeons" (physicians), and approximately 4400 affiliated health professionals including: registered dispensing opticians, spectacle lens dispensers, contact lens dispensers, licensed midwives, research psychoanalysts, medical assistants, and drugless practitioners (closed classification.) In addition to licensing health practitioners the board also: sets standards for minimum education and training required for licensure; administers various examinations; investigates complaints against licensees and takes disciplinary action against those licensees for violations of the law; administers a Diversion Program for physicians impaired by alcohol, drugs or mental disease; and provides information about its licensees and its administrative responsibilities to the public and others.

Besides physicians and the affiliated health occupations mentioned above, several other health professions and occupations were placed within the board's "jurisdiction" either directly or through examining committees. These are: Acupuncture Committee, Hearing Aide Dispensers Examining Committee, Physical Therapy Examining Committee, Physician Assistant Examining Committee, Board of Podiatric Medicine, Board of Psychology, Respiratory Care Board, and the Speech, Language, Pathology and Audiology Examining Committee. Over time, the statutes regulating these other occupations have been amended to make the examining committees for these other occupations more or less autonomous in their regulation of those professions - and some of those agencies have changed their names to "board" to reflect that they now are the state licensing agency for their particular professions.

A physician's scope of practice is defined in B&P Code Section 2051 as authorizing a licensed physician to use drugs or devices in and upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions. This is an unlimited scope of medical practice. California only issues one general medical license and does not issue any specialty medical licenses (e.g., physicians who specialize, such as an obstetrician, still only obtain a single, general medical license and rely on obtaining private specialty certification for their practice specialty.)

The Medical Practice Act provides that licensed physicians are entitled to use the initials "M.D." (for Medical Doctor), and prohibits persons not licensed as physicians from using the terms "doctor," or "physician," "Dr.," or "M.D." to indicate or imply that they are licensed to practice medicine.

All 50 states license physicians, various federal laws require that physicians must be licensed to participate in federally funded programs such as Medicare and Medicaid, and health facilities that receive federal funding must meet various requirements including that practitioners in those facilities must have current state licenses.

Improvements which the Medical Board has made over the past several years include:

- Centralized and improved its complaint intake and initial case review processes.

- Improved its triage and prioritization of disciplinary cases

- Beginning in 1995, created a selected group of trained expert medical reviewers in all medical specialties throughout the state to assist it in evaluating quality of medical care in disciplinary cases.

- Commissioned a study of closed disciplinary cases to determine whether objective criteria could be used to help determine the kinds of cases that should be given investigative priority

- Established a "Ten Point" Plan establishing specific goals to improve the timeliness and efficacy of the board's enforcement efforts.

- Increased its disclosure of information to the public regarding its licensees, and entered into an agreement with the Department of Health Services to assist the board in improving its public outreach efforts.

- Completed a Strategic Plan that establishes goals and objectives for all of the board's operations, and a established a three year plan for maintaining and improving its data processing capabilities.

- Increased its recovery of investigative and prosecutorial costs in disciplinary cases in keeping with the recommendations of the State Auditor's 1995 report on the board.

- Developed improved tracking and reporting of the activities performed by its investigative personnel, and worked with the Attorney General's Health Quality Enforcement Section to place attorneys in district offices of the board to reduce the time required to file administrative accusations in disciplinary cases and improve investigative performance.

There are approximately **104,046** physicians licensed by the Board for FY 1996/97. The following provides licensing data for the past four years:

LICENSING DATA FOR PHYSICIANS AND SURGEONS	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Total Licensed	Total: **102,076**	Total: **102,622**	Total: **103,130**	Total: **104,046**
California	76,411	77,311	78,169	79,048
Out-of State	25,665	25,311	24,961	24,998
Applications Received	Total: **4,017**	Total: **3,570**	Total: **4,663**	Total: **4,207**
Applications Denied	Total: **8**	Total: **3**	Total: **4**	Total: **5**
Licenses Issued	Total: **3,501**	Total: **3,741**	Total: **3,251**	Total: **3,574**
Foreign Graduates	829	897	764	800
Renewals Issued	Total: **49,955**	Total: **50,663**	Total: **51,348**	Total: **51,608**
Statement of Issues Filed	Total: **3**	Total: **4**	Total: **2**	Total: **4**

Statement of Issues Withdrawn	Total: **1**	Total: **0**	Total: **0**	Total: **0**
Licenses Denied	Total: **5**	Total: **3**	Total: **5**	Total: **2**
Licenses Granted	Total: **1**	Total: **2**	Total: **1**	Total: **2**

Besides physicians, there are approximately 4400 affiliated health practitioners regulated by the Medical Board including licensed midwives, registered dispensing opticians, spectacle lens dispensers, contact lens dispensers, and research psychoanalysts. The following chart provides the number of each of these practitioners licensed by the board over the past four fiscal years.

OTHER LICENSURE CATEGORIES	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Total Licensees (By Type)	Total: **4,587**	Total: **4,273**	Total: **3,962**	Total: **4,359**
Midwives	0	0	3	40
Regis. Dispensing Opticians	1,723	1,347	1,204	1,395
Spectacle Lens Dispenser	1,938	2,230	2,076	2,271
Contact Lens Dispensers	867	642	578	584
Research Psychoanalyst(s)	59	54	61	69
Licenses Issued (By Type)	Total: **414**	Total: **444**	Total: **385**	Total: **476**
Midwives	0	1	3	37
Regis. Dispensing Opticians	199	119	91	120
Spectacle Lens Dispenser	162	236	235	285
Contact Lens Dispensers	51	86	47	28
Research Psychoanalyst(s)	2	3	9	6
Renewals Issued (By Type)	Total: **3,720**	Total: **169***	Total: **3,503**	Total: **2,816**
Midwives	0	0	0	0
Regis. Dispensing Opticians	1,278	15*	1,386**	679
Spectacle Lens Dispenser	1,878	111*	1,597	1,488
Contact Lens Dispensers	516	41*	462	647
Research Psychoanalyst(s)	48	2	58	2

*****Low numbers are a result of conversion to a biennial renewal.
**Reflects a number of duplicate renewals due to conversion to birth date renewal cycle.

BUDGET AND STAFF

Current Fee Schedule and Range

The board has an annual budget of approximately $32 million, and a staff of over 300 employees located in 12 district offices around the state. The board's sources of revenue are primarily licensing and renewal fees from physicians, license application and examination fees, disciplinary cost recovery, administrative fines and various reimbursements (e.g., fingerprint verification fees.) The board is entirely special funded with no General Fund monies used to fund the operation of the board. Licenses are renewed biennially, with the initial license fee currently set at the statutory maximum of $600. The current renewal fee is established by regulation at $575, increasing to the statutory maximum of $600 next February. The board's fund condition projections show that it will face a fund deficit in several years (by FY 2001/2002) - assuming current projections for its share of the Department of Consumer Affairs proposed new licensing and disciplinary data processing system remain as currently projected. This deficit projection does not account for any additional program requirements that could result from legislative mandates, additional enforcement program

costs, or additional enforcement staffing (e.g., additional investigators to reduce excessive current caseloads.)

The board is anticipating that despite efforts to reduce costs, streamline its operations, and increase its disciplinary cost recovery, it will need to increase its license fees to maintain a stable and positive fund balance with an adequate reserve for contingencies. The following table shows the primary fees collected by the board for its licensure of physicians.

Fee Schedule	Current Fee	Statutory Limit
Application Fee	$ 442	Actual Costs
Exam Fee - USMLE	$ 300	Actual Costs
Admin. Fee - USMLE	$ 100	Actual Costs
Oral Exam Fee	$ 100	$ 100
Original License Fee	$ 600	$ 600
Renewal Fee	$ 575	$ 600
Retired License Fee	$ n/a	$ n/a

Revenue and Expenditure History

The Medical Board's revenues have been increasing slightly over the past four years, while its expenditures have increased somewhat more significantly. Most of the board's revenues are derived from license fees paid by its licensees, with the remainder generated from reimbursements for costs (e.g., fingerprints), interest on fund monies, or periodic repayments of the board's licensing fees that were transferred to the General Fund in 1992 to help with a budget deficit that year.

REVENUES	ACTUAL				PROJECTED	
	FY 93-94	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Licensing Fees	$28,151,014	$30,687,901	$30,904,739	$31,027,686	$31,739,930	$31,731,730
Fines & Penalties	$94,485	$79,988	$72,662	$86,221	$77,500	$77,500
Other	$75,988	$42,300	$41,645	$12,956	$36,570	$36,570
Interest	$173,399	$315,505	$218,068	$314,263	$265,000	$250,000
TOTALS	**$28,494,886**	**$31,125,694**	**$31,237,114**	**$31,441,126**	**$32,119,000**	**$32,095,800**

EXPENDITURES	FY 93-94	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99
Personnel Services	$13,585,268	$14,289,677	$14,984,672	$15,164,877	$15,755,580	
Operating Expenses	$17,095,011	$18,146,380	$18,502,731	$18,154,346	$16,990,971	
(-) Reimbursements	$431,502	$565,551	$839,015	$1,134,163	$307,000	
(-) Distributed Costs	$1,266,000	$878,964	$821,153	$791,786	$838,000	
TOTALS	**$28,982,777**	**$30,991,542**	**$31,827,235**	**$31,393,274**	**$31,601,551**	

Expenditures by Program Component

The Medical Board spends the largest proportion of its budget on enforcement - over $22 million or 70%. This does not include the almost $800,000 spent annually on the board's operation of the impaired physician Diversion Program (with 230 or so participants) or the $871,300 spent annually on the board's probation monitoring program. The former is a program conducted in lieu of enforcement while the latter is a result of disciplinary actions of the board. Licensing and examination programs of the board account for only about $3.6 million or 11% of the budget, with executive services representing 4% ($1.2 million), support services at 5% ($1.5 million), and information systems also about 5%.

Increased costs for the enforcement program component are anticipated to occur from increasing complaints to the board, and the additional complexity and resultant delays in obtaining case closures. Besides the perceived increase in resistance by licensees to disciplinary action, the recent changes to the Administrative Procedure Act are anticipated to further increase case complexity and duration.

EXPENDITURES BY PROGRAM COMPONENT	FY 93-94	FY 94-95	FY 95-96	FY 96-97	Average % Spent by Program
Enforcement	$20,996,615	$22,376,740	$22,559,844	$22,063,660	**70%**
Licensing	$2,738,989	$3,468,701	$3,638,288	$3,596,773	**11%**
Executive	$1,165,136	$1,315,522	$1,202,196	$1,210,623	**4%**
Support Services	$1,243,106	$1,188,020	$1,488,606	$1,531,667	**5%**
Information Systems	$1,293,855	$1,062,249	$1,215,724	$1,325,312	**5%**
Diversion	$739,431	$736,568	$763,471	$793,936	**3%**
Probation Monitoring	$670,998	$843,742	$959,106	$871,300	**3%**
TOTALS	**$28,982,777**	**$30,991,542**	**$31,827,235**	**$31,393,271**	

Fund Condition

The board's fund condition statement indicates that over the next few years, necessary and anticipated expenditures will exceed its revenues, leading to a decline in its fund, and ultimately a deficit at least by the year 2001. At the end of FY 96/97 the board had a fund balance reserve of $5.45 million (2 months reserve.) That is expected to drop at the end of the current fiscal year (FY 97/98) to $4.2 million (1.5 months reserve), and continue to decline over the next three years with a $900,000 deficit in FY 2001/2002. The license renewal fee is required by statute to be set in regulation so as to maintain but not exceed a two month reserve in the fund. (This appears to be designed to maintain a low fund balance in the event of any attempted future General Fund raid. However, this doesn't seem to give the board much of a prudent reserve for other medical practice related contingencies.)

ANALYSIS OF FUND CONDITION	FY 96-97	FY 97-98 (Budget Yr)	FY 98-99 (Projected)	FY 99-00 (Projected)	FY 00-01 (Projected)	FY 01-02 (Projected)
Total Reserves, July 1	$5,011,000	$5,059,000	$5,458,000	$4,218,000	$3,257,000	$1,548,000
Total Rev. & Transfers	$31,441,000	$32,114,000	$32,047,000	$32,009,000	$31,920,000	$31,855,000
Total Resources	$36,452,000	$37,173,000	$37,505,000	$36,227,000	$35,177,000	$33,403,000
Total Expenditures	$31,393,000	$31,715,000	$33,287,000	$32,970,000	$33,629,000	$34,302,000
Reserve, June 30	$5,059,000	$5,458,000	$4,218,000	$3,257,000	$1,548,000	($899,000)
MONTHS IN RESERVE	**1.9**	**2.0**	**1.5**	**1.2**	**0.5**	**- 0.3**

LICENSURE REQUIREMENTS

Education, Experience and Examination Requirements

The requirements for licensure as a physician in California are:

1. Two years of pre-professional, postsecondary education

2. 32 months of medical curriculum instruction along with 72 weeks of clinical instruction covering specified subjects.

3. Graduation from a medical school

4. Passage of all parts of one of three approved written medical examinations (NBME, FLEX, or the USMLE)

5. One year postgraduate training in an approved postgraduate training program (residency training). For graduates of foreign medical schools, admission to such postgraduate training requires certification by the Educational Commission on Foreign Medical Graduates (ECFMG) involving passage of the first two parts of the USMLE or one of several combinations of parts of the USMLE, NBME, and FLEX exams; and passage of an English language exam.

6. Passage of the Computerized Special Purpose Examination (CSPEX) for certain individuals who have graduated from a foreign medical school and have been practicing more than four years elsewhere in the U.S. under an unrestricted license.

7. Passage of an oral examination on general medical diagnosis and treatment for foreign medical school graduates, licensees of other states whose NBME certification was obtained five or more years previously, and former licensees who are reapplying for licensure after allowing their license to expire after five years of non-renewal.

For licensure as a midwife, California requires:

Either: (1) completion of an accredited, three-year postsecondary midwifery education program with a specified curriculum, and passage of a comprehensive licensing examination that is equivalent to the examination given by the American College of Nurse Midwives; or (2) successful completion of an equivalent program, and current licensure as midwife by a state with licensing standards equivalent to California.

Registration as a registered dispensing optician is essentially a business license that does not have any educational or training prerequisites. Registration as a spectacle lens dispenser does not require any specified education or training but does require passage of the registry examination of the American Board of Opticianry. Registration as a contact lens dispenser similarly has no educational or training prerequisites but does require passage of the registry examination of the National Committee of Contact Lens Examiners. Both of the latter are national examinations which were last validated in 1995.

There is no examination prerequisite for research psychoanalysts though they must be graduates of an approved psychoanalytic institute or a student therein.

Unlicensed medical assistants must have obtained adequate training by their supervising physician or podiatrist prior to performing tasks other than administrative or clerical tasks - i.e., prior to performing “technical supportive services.” There is no examination requirement as such.

Drugless practitioner is a ""closed" license classification (since 1949) - for which only license renewal remains without any educational, training or examination prerequisites.

For the Comparison of Exam Passage Rates for All Candidates, both Nation-wide and in California, for both the current USMLE written medical licensure exam - See Table on next page.

UNITED STATES MEDICAL LICENSE EXAM (USMLE) PASS RATE FOR ALL CANDIDATES NATION-WIDE

YEARS	NATION-WIDE		CALIFORNIA ONLY	
	TOTAL CANDIDATES	PASSAGE RATE	TOTAL CANDIDATES	PASSAGE RATE
1993/94	856*****	41%	53******	71%
1994/95	14,955	89%	1,658	91%
1995/96	22,592	85%	2,349	88%
1996/97	27,271	82%	2,466	86%

***** Majority of candidates were graduates of international schools.
******The USMLE exam replaced the FLEX exzm in June 1994. The passage rate for the FLEX exam for that year was 80% for the 297 applicants who took the exam. The SPEX exam was also discontinued in 1994/95. The average passage rate for the SPEX exam was about 65% for 1993-95.

For the passage rate by medical license applicants taking California's oral examination - See Table Below. The passage rate for this oral examination is quite high as can be see from the table.

CALIFORNIA ORAL EXAMINATION PASS RATE

	1993/94	1994/95	1995/96	1996/97
CANDIDATES	1,204	1,086	987	1,117
PASS %	96%	95%	96%	97%
NOTE:				

The time taken by the board to process license applications and subsequently issue a license does not appear to be a problem. The amount of time varies from applicant to applicant since some persons have completed more of the prerequisites at the time they initially apply than others. The board requires documentation to accompany the application regarding the completion of the licensing prerequisites (medical school graduation, postgraduate residency

training, passage of specified examinations, etc.) and carefully cross-checks that information first hand.

AVERAGE DAYS TO RECEIVE LICENSE	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Application to Examination				
Examination to Issuance				
Total Average Days				

Continuing Education/Competency Requirements

Licensed physicians are required to complete a minimum of 100 hours of continuing medical education (CME) every four years, and complete an average of 25 hours each year. The board conducts a random audit of 1% of its total licensee population to assure compliance with these requirements.

The board, by regulation, recognizes three organizations that accredit CME courses offered at approximately 2500 medical schools, teaching hospitals and specialty boards/programs. Each course must have an evaluation method such as a written examination or evaluation by participants. The coursework must be directed towards the practice of medicine. The CME requirement can be waived by the board but must be made up during the next two-year renewal cycle, in addition to that cycle's CME requirements (i.e., 150 hours by the end of six years) or the license will not subsequently be renewed. The board has established a Physician Requalifications Committee to evaluate the current CME requirements and other alternatives to assure continued competency.

Licensed midwives are required to take at least 36 hours of continuing education in areas that fall within the scope of midwifery practice, as specified by the Medical Board. There are no continuing education requirements for registered dispensing opticians, spectacle or contact lens dispensers, research psychoanalysts, drugless practitioners or medical assistants.

Comity/Reciprocity With Other States

Applicants for a California physician's license who are licensed in other states may obtain a California license if they meet all of the following requirements: (1) Hold an unlimited license in another state that was issued upon the basis of successful completion of at least one year of postgraduate instruction that meets California's postgraduate residency requirements, and passage of a written examination that is equivalent to that accepted by California; (2) Active licensed medical practice for a period of at least four years in the U.S., Canada, or the U.S. military or other federal program; (3) No disciplinary record elsewhere; (4) For foreign medical school graduates - passage of a specified written clinical competency examination (CSPEX) or its equivalent; (5) Passage of an oral examination (on general medical diagnosis and treatment); and (6) No violation of the general statutory grounds for license denial in California (e.g., conviction of a crime, etc.)

Essentially this requirement means that foreign-educated medical school graduates licensed and practicing elsewhere must have one year approved postgraduate training, pass a special

written clinical exam (CSPEX) and a general oral exam. Similar applicants who have graduated from an approved U.S. or Canadian medical school need not take the specialized written clinical exam (CSPEX).

ENFORCEMENT ACTIVITY

ENFORCEMENT DATA	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Inquiries	Total: **80,484**	Total: **74,822**	Total: **77,217**	Total: **77,056**
Complaints Received (Source)	Total: **7,902**	Total: **11,465**	Total: **11,497**	Total: **10,123**
Public	5,305	6,601	6,418	6,372
B&P Code Section 800*	1,187	1,050	1,141	1,382
Licensee/Professional Group	267	176	205	253
Governmental Agencies	938	3,505**	3,609**	1,923
Other	205	133	124	193
Complaints Filed (By Type)	Total: **7,394**	Total: **11,094**	Total: **10,988**	Total: **9,484**
Competence/Negligence	3,696	8,002	7,965	6,317
Unprofessional Conduct	2,471	2,009	1,945	2,052
Fraud	470	332	284	268
Health & Safety	265	312	274	294
Unlicensed Activity	281	258	257	260
Personal Conduct	211	181	263	293
Complaints Closed	Total: **5,614**	Total: **11,058**	Total: **9,751**	Total: **8,161**
Investigations Commenced	Total: **2,046**	Total: **2,041**	Total: **1,998**	Total: **2,039**
Compliance Actions	Total: **231**	Total: **195**	Total: **330**	Total: **380**
ISOs & TROs Issued	21	20	29	37
Citations and Fines	3	57	152	214
Public Letter of Reprimand	9	25	67	39
Cease & Desist/Warning	9	1	3	6
Called in for Medical Review	138	37	44	25
Referred for Diversion	31	18	19	44
Compel Examination	20	37	16	15
Referred for Criminal Action	Total: **87**	Total: **73**	Total: **68**	Total: **47**
Referred to AG's Office	Total: **607**	Total: **416**	Total: **510**	Total: **567**
Accusations Filed	407	353	262	296
Accusations Withdrawn	41	69	67	57
Accusations Dismissed	13	10	12	11
Stipulated Settlements	Total: **121**	Total: **216**	Total: **214**	Total: **211**

Disciplinary Actions	Total:	**206**	Total:	**307**	Total:	**274**	Total:	**278**
Revocation		62		65		62		49
Voluntary Surrender		28		62		52		87
Suspension Only		0		2		1		0
Probation with Suspension		39		34		29		27
Probation		75		141		129		112
Probationary License Issued		2		3		1		3
Probation Violations	Total:	**10**	Total:	**14**	Total:	**17**	Total:	**14**
Suspension or Probation		3		7		5		4
Revocation or Surrender		7		6		8		14

*****Includes complaints initiated based upon reports submitted pursuant to Business and Professions Code Section 800 et seq. which requires reporting from hospitals, insurance companies, attorneys, courts of health facility discipline (805 reports), malpractice judgments/settlements, etc.

******Complaints increased due to increased processing of new and backlogged National Practitioner Data Bank reports regarding actions taken in other states against California-licensed physicians.
Processing the backlog was completed in 12/1/95.

Enforcement Program Overview

The Medical Board reports that it has been successful in getting itself listed in the various telephone directories throughout the state - using being listed in the State Government listings of the "white" pages under consumer protection or alphabetically. The board maintains a toll-free (800) telephone number where consumers can obtain information about the complaint process, a complaint form and information including formal disciplinary actions about licensees of the board.

Various provisions of the Business and Professions Code require licensees, licensees' employers, liability insurers, court clerks, and prosecutors to report to the board regarding criminal or civil cases brought against licensees, and judgments, arbitration awards and settlements over $30,000 in medical malpractice cases. Further, peer review organizations such as those in hospitals and health facilities are required to report to the board any actions which lead to: a denial, restriction, suspension, or termination of a licensee's staff privileges, or a licensee's resignation or leave of absence following notice of an impending peer review investigation for a medical disciplinary cause or reason (referred to as Section 805 Reports.) These various sources of information are intended to alert the board regarding possible practice problems regarding a licensee so that the board may investigate to determine if disciplinary action is warranted.

Several years ago the board centralized all of its complaint intake to the Central Complaint and Investigation Control Unit (CCICU) instead of having complaints handled disparately by each of the board's district offices. The board received approximately 10,123 complaints regarding physicians and surgeons during FY 96/97. Complaints are reviewed by consumer services representatives at the CCICU, and by an in-house medical consultant if they relate to quality of medical care. The vast majority of the complaints received by the board about physicians were regarding incompetence or negligence (6,317) and unprofessional conduct (2,052). The CCICU resolves about 65% of the complaints without having to refer those cases out to the district offices for investigation (8,161 in FY 96/97). The time period for resolving complaints in this manner has decreased from 142 days in FY 92/93 to 64 days in FY 96/97.

Cases where sufficient evidence of a violation exists and which are not resolved by the CCICU are referred to one of the board's 12 district (field) offices for assignment to an investigator. The cases are reviewed there by the Supervising Investigator and a medical

consultant prior to assignment. Following an investigation, cases involving quality of care are referred to a medical expert reviewer for an evaluation. Upon conclusion of an investigation, a decision is made whether to refer the case to the Attorney General for the filing of a formal accusation. In cases of serious potential ongoing harm to the public the board will seek to obtain a temporary restraining order (TRO) from a court or an interim suspension order (ISO) from an administrative law judge to immediately suspend a physician's practice.

Cases referred to the AG are reviewed and it is determined whether to file an formal accusation. The licensee has the right to an administrative hearing conducted in accordance with the Administrative Procedure Act, followed by the right to seek judicial review through a Writ of Mandate to the Superior Court, followed by appellate review up to the Supreme Court.

The board's statistics indicate that it commenced about 2,039 investigations during FY 96/97 (about the same as in the previous three years), referred 47 cases that same year to a district attorney for criminal prosecution, referred 567 investigated cases to the AG for filing accusations, and reached stipulated settlements with licensees in 68 cases. During the past three years the number of investigations has remained about the same, with more cases being referred to the AG. During FY 96/97 the board obtained 278 disciplinary actions, including 49 revocations, 87 license surrenders, 27 suspensions with probation, 112 probations, and issued three probationary licenses. The overall number of disciplinary actions has been about the same over the past three years, with a decrease in revocations, and an increase in voluntary license surrenders.

Significant problems reported by the board in improving its enforcement efforts, despite various program and procedural improvements include, but are not limited to: unreasonably heavy investigator caseload, lack of compliance by physicians in providing patient medical records, lack of compliance with the Section 805 peer review and other reporting requirements, and outdated, ineffective data processing capabilities with the current computer enforcement tracking system (the Department of Consumer Affairs' CAS system).

NUMBER AND PERCENTAGE OF COMPLAINTS DISMISSED, REFERRED FOR INVESTIGATION, TO ACCUSATION AND FOR DISCIPLINARY ACTION

	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
COMPLAINTS RECEIVED	**7,902**	**11,465**	**11,497**	**10,123**
Complaints Closed	5,614 (71%)	11,058(96%)	9,751 (85%)	8,161 (81%)
Referred for Investigation	2,046 (26%)	2,041 (18%)	1,998 (17%)	2,039 (20%)
Accusation Filed	407 (5%)	353 (3%)	262 (2%)	296 (3%)
Disciplinary Action	206 (3%)	307 (3%)	274 (2%)	278 (3%)

Case Aging Data

The tables below reflect the average time it has taken for the board to process, investigate and prosecute its disciplinary cases, and the average time it has taken for the board's investigators to complete investigations and the Attorney General to prosecute them to final closure. The latter time frame (closure) includes not only the time to completion of an administrative hearing where stipulations have not been reached beforehand, but also any time involved in appeals of cases to the civil courts (Superior, Court of Appeal and Supreme Court.)

The board's statistics appear to reflect that over the past four fiscal years: the time it takes to process complaints has decreased significantly, the average time it takes to investigate complaints that are referred for investigation has remained relatively the same (about one year), the amount of time for the Attorney General to file an accusation (pre-accusation time frame) has decreased significantly, but the time it takes to actually prosecute a case to closure (post-accusation time frame) has remained about the same - about 500 days after an accusation is filed.
The total average amount of time, from the filing of a complaint to final closure, has decreased slightly from four years ago (1252 days in FY 92/93 to 1,042 days in FY 96/97 - but still three years), and has remained constant the past two years.

AVERAGE DAYS TO PROCESS COMPLAINTS, INVESTIGATE AND PROSECUTE CASES				
	FY 1993/94	**FY 1994/95**	**FY 1995/96**	**FY 1996/97**
Complaint Processing	145	91	65	64
Investigations	306	345	335	336
Pre-Accusation*	290	230	139	134
Post-Accusation**	511	538	495	508
TOTAL AVERAGE DAYS* **	**1,161**	**1,225**	**1,127**	**1,130**

*****From completed investigation to formal charges being filed.
******From formal charges filed to conclusion of disciplinary case.
*******From date complaint received to date of final disposition of disciplinary case.

The statistics in the table below appear to indicate that the number of investigations completed over the past three years has increased, with some increase in the number of investigations closed within 90 days, 180 days and 1 year. The statistics also seem to reflect an increase in the number of cases being closed by the AG , and a decrease in the age of those cases.

The board has centralized its complaint intake during this time so that all complaints are first reviewed in the Central Complaint Unit in Sacramento by consumer service representatives and a medical consultant to determine the need for a field investigation, The board reports that 65% of its complaints are being closed at that stage without an investigation (an increase) - apparently reflected in the decreased time frame for complaint processing. Also, the number of disciplinary cases still pending at the AG's office (backlog) appears to have steadily decreased over the past four years. However, the amount of time it takes to discipline a licensee still appears to take a very long time in many cases.

Enacted in 1990, Section 2319 of B&P Code set a legislative goal of 6 months for the Board to process complaints and investigate cases, or up to 1 year for more complex cases. Medical Board cases are still taking, on average, about 13 months to process and investigate, and almost 3 years on average to prosecute to a final disposition. The board did report a significant increase in the number of complaints filed (from 6,730 in 92/93 to over 10,000 in 96/97.) Further, the board notes that investigations are being completed in 75% of its cases within the 180 day goal. The board has made efforts to streamline its investigative process, reducing the number of medical reviewers required from two to one, automating its investigative staff with laptop computers and cellular telephones, enhancing its investigator activity reports, among other improvements. Also, a pilot project begun just this year to have deputy AGs perform case reviews in selected district offices of the board appears to be significantly reducing the time it takes to get accusations filed, and also appears to improve

the investigative process by eliminating unnecessary investigative work and improving the quality of the investigations sent to the AG for filing.

INVESTIGATIONS CLOSED WITHIN:	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97	AVERAGE % CASES CLOSED
90 Days	219 (10%)	282 (14%)	454 (22%)	505 (22%)	**17%**
180 Days	294 (14%)	198 (10%)	199 (9%)	289 (13%)	**12%**
1 Year	533 (25%)	417 (21%)	396 (19%)	450 (20%)	**21%**
2 Years	746 (33%)	658 (33%)	544 (28%)	521 (23%)	**29%**
3 Years	249 (21%)	305 (15%)	313 (15%)	302 (13%)	**16%**
Over 3 Years	75 (10%)	115 (5%)	128 (6%)	182 (8%)	**7%**
Total Cases Closed	**2,116**	**1,975**	**2,034**	**2,249**	
AG CASES CLOSED WITHIN:	**FY 1993/94**	**FY 1994/95**	**FY 1995/96**	**FY 1996/97**	**AVERAGE % CASES CLOSED**
1 Year	100 (28%)	109 (21%)	153 (32%)	222 (44%)	**31%**
2 Years	118 (33%)	186 (36%)	146 (30%)	139 (27%)	**31%**
3 Years	76 (21%)	114 (22%)	93 (20%)	67 (13%)	**19%**
4 Years	35 (10%)	61 (12%)	47 (9%)	46 (9%)	**10%**
Over 4 Years	29 (8%)	47 (9%)	36 (7%)	35 (6%)	**8%**
Total Cases Closed	**358**	**517**	**475**	**509**	
Disciplinary Cases Pending	**920**	**719**	**605**	**539**	

Cite and Fine Program

The board implemented administrative citations and fines in 1994. The board believes that this disciplinary option, along with its Public Letter of Reprimand, has been a highly efficient and effective means of providing public protection in an equitable fashion for minor violations by licensees. The board can issue a citation with or without a fine attached - and the fines are authorized to range from $100 to $2500 for each violation of the law.

Typically the board will identify cases where minor violations are believed to exist and decide to issue a citation or citation and fine instead of pursuing more time consuming and costly formal disciplinary action via an accusation. The licensee is notified of a pending citation/fine and given the opportunity to accept or reject it. If it's rejected the board may proceed with formal disciplinary action.

The following table reflects the board's use of citations and fine, with an increase over the first year, though the number and amounts assessed and collected have generally remained relatively stable for FYs 94/95, 95/96, and 96/97 (save for a higher number of citations but not fine amounts in FY 96/96).

CITATIONS AND FINES	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Total Citations	0	1	62	141
Total Citations With Fines	3	56	90	73
Amount Assessed	$1,750	$59,350	$60,050	$60,080
Reduced, Withdrawn, Dismissed	$500	$34,050	$20,800	$16,650
Amount Collected	**$1,250**	**$25,300**	**$35,000**	**$29,050**

Diversion Program

Since 1980, the Medical Board has been authorized to operate a diversion program for physicians impaired by alcohol, drugs, or mental disease. California appears to be one of only two states whose medical licensing boards operate their own program rather than contracting with a private consultant or organization to conduct it. (Most other licensing agencies in the Department of Consumer Affairs contract with such a private drug/alcohol counseling program.) Physicians may participate in the program voluntarily (self-referral) or as a result of disciplinary action by the board. Participants must be evaluated by special Diversion Evaluation Committees established by the board in different areas of the state - who determine the suitability of the licensee to participate in the program without endangering the public and the potential for rehabilitation. Admission to the program serves as an alternative to disciplinary action for participants since disciplinary action cannot be taken against an accepted participant for the same acts that led to his acceptance into the program. Those acts (violations of the law) may only relate to the self-administration or illegal possession or non-violent procurement for self-administration, where there is no actual harm to patients.

Participants must pay $235/mo. to counselors who conduct twice-weekly group therapy sessions, as well as $43 for two urine tests each month. Any intensive residential treatment must be paid for by the participant. The table below shows the costs over the past four years to the Medical Board for its costs to operate its Diversion Program. Those costs are nearly $800,000 per year. There are about 213 licensee participating in the program, According to the board, since its inception in 1980, over 800 participants have entered the program, 564 of those successfully completed the program (with 38 re-entering it subsequently.) According to the board's report, there were 35 successful completionís during FY 96/97, while 21 licensee participants were unsuccessful. Participants who leave the program prior to successful completion face revival of disciplinary action against their licensees.

DIVERSION PROGRAM STATISTICS	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Total Program Costs	$739,431	$721,595	$763,472	$786,000
Total Participants	213	204	203	213
Successful Completions	44	43	35	35
Unsuccessful Completions	19	16	21	21

Results of Complainant Survey

The JLSRC directed all board's and committees under review this year to conduct a consumer satisfaction survey to determine the public's views on certain case handling parameters by those agencies. The JLSRC supplied both a sample format and a list of seven questions, and indicated that a random sampling should be made of consumers whose complaints were closed in FY 96/97. Consumers who filed these complaints were asked respond to the questions using a 5-point grading system - with 5=satisfied to 1=dissatisfied.

The results of the Medical Board's survey reflects satisfaction (or dissatisfaction) with the board's handling of consumer complaints. The board mailed out 721 surveys, of which 322 were returned. While 43% of the respondents were very satisfied with knowing where to file a complaint, their satisfaction dropped significantly when it came to how well the board kept

them informed about their complaint status (19% very satisfied and 40% very dissatisfied), the time it took to process a complaint (19% very satisfied vs. 45% very dissatisfied) and the final outcome of the case (10% very satisfied vs. 69% very dissatisfied. 46% were very dissatisfied with the board's overall service, and only 16% were very satisfied.

CONSUMER SATISFACTION SURVEY RESULTS*					
QUESTIONS	**RESPONSES**				
# Surveys Mailed: 721 **# Surveys Returned: 322 (45%)**	***SATISFIED***			***DISSATISFIED***	
	5	***4***	***3***	***2***	***1***
1. Were you satisfied with knowing where to file a complaint and whom to contact?	43%	21%	13%	5%	17%
2. When you initially contacted the Board, were you satisfied with the way you were treated and how your complaint was handled?	34%	22%	13%	8%	23%
3. Were you satisfied with the information and advice you received on the handling of your complaint and any further action the Board would take?	21%	12%	14%	8%	44%
4. Were you satisfied with the way the Board kept you informed about the status of your complaint?	19%	12%	17%	11%	40%
5. Were you satisfied with the time it took to process your complaint and to investigate, settle, or prosecute your case?	19%	11%	12%	11%	45%
6. Were you satisfied with the final outcome of your case?	10%	7%	4%	6%	69%
7. Were you satisfied with the overall service provided by the Board?	**16%**	**11%**	**14%**	**12%**	**46%**

*****The JLSRC directed all board's and committee's under review this year, to conduct a consumer satisfaction survey to determine the public's views on certain case handling parameters. (The Department of Consumer Affairs currently performs a similar review for all of its bureau's.) The JLSRC supplied both a sample format and a list of seven questions, and indicated that a random sampling should be made of closed complaints for FY 1996/97. Consumers who filed complaints were asked to review the questions and respond to a 5-point grading scale
(i.e., 5=satisfied to 1=dissatisfied).

ENFORCEMENT EXPENDITURES AND COST RECOVERY

Average Costs for Disciplinary Cases

The average investigation costs have decreased over the past three years, from $6,673 per case to $5,247. This reflects a lower overall annual enforcement expenditure for investigations and an increase in the number of investigations completed during a year. The average costs for the AG's office (prosecution) have also decreased during that same period, apparently reflecting a lower overall expenditure and an increase in the number of cases closed by the AG during that period. However, some cases referred to the AG in 96/97 will be worked and billed on in later fiscal years.

AVERAGE COST PER CASE INVESTIGATED	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Cost of Investigation & Experts	$12,712,000	$13,263,000	$12,916,000	$11,834,000
Number of Cases Closed	2,231	1,988	2,043	2,255
Average Cost Per Case	$5,697	$6,672	$6,322	$5,247
AVERAGE COST PER CASE REFERRED TO AG	**FY 1993/94**	**FY 1994/95**	**FY 1995/96**	**FY 1996/97**
Cost of Prosecution & Hearings	$7,021,000	$7,793,000	$8,162,000	$7,545,000
Number of Cases Referred	607	416	510	567
Average Cost Per Case	$11,567	$18,733	$16,003	$13,306
AVERAGE COST PER DISCIPLINARY CASE	**$17,264**	**$25,405**	**$22,325**	**$18,553**

Cost Recovery Efforts

The board implemented disciplinary cost recovery beginning in FY 92/93 pursuant to the authority provided in B&P Code Section 125.3. That law authorizes licensing agencies within the Department of Consumer Affairs to recover from licensees the reasonable costs of investigation and enforcement (including the costs of prosecution by the AG) up to the time of administrative hearing, if any, where the licensing agency prevails in the case.

A March 1995 report by the State Auditor found that the Medical Board was not maximizing its recovery of its investigative and prosecutorial costs in either stipulated agreements with licensees or in the proposed decisions in administrative hearings by administrative law judges of the Office of Administrative Law. The State Auditor noted that the board had only recovered $94,053 of its costs during FY 93/94 - while the auditor estimated that the board had accrued potentially $6.3 million in recoverable costs out of its total enforcement costs of $21.6 million during that period (0.3%). The State Auditor also recommended that the board could further increase its recoverable enforcement costs if it were to obtain statutory authority to request recovery of its costs for prosecution of the case during the administrative hearing.

While the actual cost recovery amounts requested are not tracked on its automated system, the board has been increasing the amount of its cost recovery since FY 93/94 - with $759,000 recovered during FY 96/97 (or 3.3% of its $22,935,000 enforcement costs.) It also appears that due to the board's improved time tracking and reporting of its investigators activity on cases, and more detailed billings from the Attorney General as to its costs, the board is more successful in substantiating and obtaining cost recovery.

The board notes that because such cost recovery in individual cases is often in the thousands of dollars, it will accept cost recovery payment plans from licensees that extend over a number of years. Also, the board will reduce the amount of cost recovery it will request in stipulated agreements with licensees in trade for obtaining the licensee's

agreement to other disciplinary probation terms and conditions deemed important by the board.

COST RECOVERY DATA	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Enforcement Expenditures	$21,668,000	$23,220,000	$23,519,000	$22,935,000
Potential Cases for Recovery*	206	309	274	278
Cases Recovery Ordered				
Amount Collected	**$95,000**	**$205,000**	**$458,000**	**$759,000**

*The "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on a violation, or violations, of the Medical Practice Act.

RESTITUTION PROVIDED TO CONSUMERS

The board indicates that in FY 95/96 it ordered $601,500 in restitution from physicians to be paid to victims or their families. The board states that in order to avoid the loss of flexibility which could adversely impact operational efficiency and effectiveness, it has not adopted any rules or guidelines identifying specific circumstances under which restitution should be ordered. Rather, the board considers restitution in disciplinary actions on a case-by-case basis. The board notes that in most disciplinary cases, the patient has not lost money but instead suffered physical or mental impairment - to which it is difficult to attach a dollar value for recovery in an administrative hearing. The board notes that medical malpractice victims pursue their own civil actions to recover damages and argues that they are more successful than the Medical Board would be in an administrative action, in part due to the lower burden of proof (preponderance of the evidence) in such civil cases.

RESTITUTION DATA	FY 1993/94	FY 1994/95	FY 1995/96	FY 1996/97
Amount Ordered	N/A	N/A	$601,500	N/A
Amount Collected	N/A	N/A	N/A	N/A

COMPLAINT DISCLOSURE POLICY

The Medical Board has adopted regulations for what information it will disclose to the public regarding its licensees. The board does not disclose consumer complaint information to the public, but will release disciplinary information regarding a licensed physician once a formal accusation has been filed. Consumers can call the board and receive information regarding a physician's license status, issuance and expiration date, medical school and date of graduation; past or pending disciplinary actions (post-accusation) including Public Letters of Reprimand, administrative citations, Interim Suspensions or Temporary Restraining Orders, revocation, suspension, or probation. The board also discloses information regarding

medical malpractice judgments or settlements in excess of $30,000 and any felony convictions.

Efforts have been made in the past to disclose even more information such as medical malpractice settlements (rather than actual judgments), misdemeanor convictions, and the existence of disciplinary cases that have been investigated and referred to the Attorney General for the filing of an accusation. The latter (pre-accusation referrals) was rejected as a result of a lawsuit brought against the board by the California Medical Association. However, AB 103 (Figueroa - Chapter 359 of 1997) will add disclosure of medical malpractice judgments and arbitration awards of any amount.

CONSUMER OUTREACH AND EDUCATION

The board provides information in a number of ways to consumers and its licensees regarding the board's role, programs and activities, the requirements and prohibitions of the Medical Practice Act, information regarding its licensees, and the board's disciplinary process. These efforts include publications, media contacts, news releases, speakers bureaus, representation at health fairs, and a toll-free (800) consumer complaint telephone line.

The board's publications include informational booklets such as: *Services to Consumers from the Medical Board of California, Breast Cancer Diagnosis and Treatment, Diagnosis and Treatment of Prostate Cancer, Guidebook to the Laws Governing the Practice of Medicine,* and the board's Consumer Complaint Form.

The board also issues press releases when physicians are disciplined as well as some informational news releases to inform consumers of their rights and positive health practices. The board meets quarterly, alternating between Northern and Southern California (Sacramento, San Franciso, Los Angeles, & San Deigo.) The board also produces a quarterly "Action Report" that is sent to all licensees and covers major board activities, legislation and legislative changes to the law, and a listing of board disciplinary actions taken against its regulated licensees (indicating name, license #, city, type of decision and effective date.)

Finally, the board has created a new "homepage" on the World Wide Web where the public can access information regarding the board, its licensees, how to file a complaint, how to order legal documents and publications. The Webpage is linked to two other homepages including the American Board of Medical Specialty's (ABMS's) database showing board-certified specialists nationwide

PART 2.

MEDICAL BOARD OF CALIFORNIA

IDENTIFIED ISSUES, FINDINGS AND COMMENTS, RECOMMENDATIONS AND FINAL ACTION OF THE JOINT LEGISLATIVE SUNSET REVIEW COMMITTEE

ISSUE #1. Should the State's licensing of physicians be continued?

Recommendation: ***Both the Department and Committee staff recommended the continued licensure of physicians.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: The public relies on physicians for a broad range of critical services regarding their health care which require a high degree of education, training, professional judgment, and complex technical skills. Incompetence and malfeasance by physicians carry the greatest potential for causing patient harm, and patients generally are not sufficiently knowledgeable or sophisticated to select practitioners in the marketplace without the state's intrusion to set minimum education and training standards. While patients have recourse to private civil action for negligence or fraud, exercise of these rights can be prohibitively costly or time consuming. Mandating a strong disciplinary role for the Medical Board to protect patients was an essential element (trade-off) in establishing the present limitations placed on civil tort actions against physicians in the mid-1970's. Further, all other states license physicians.

ISSUE #2. Should the direct licensing and/or regulation of registered dispensing opticians (RDOs), contact lens dispensers, spectacle lens dispensers, drugless practitioners, research psychoanalysts, licensed midwives, and medical assistants by the Medical Board be continued?

Recommendations: ***Both the Department and Committee staff recommended the continued regulation of registered dispensing opticians, contact lens dispensers, spectacle lens dispensers, licensed midwives and medical assistants. However, the registration of research psychoanalysts and certification of drugless practitioners should be eliminated.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: The Medical Board directly regulates several health professions besides physicians. Lay midwifery is a new program legislative created several years ago. Registered dispensing opticians, and related spectacle and contact lens dispensers, appear to require continued regulation to protect the public from incompetence regarding an important health care service. However, other regulated categories, such as research psychoanalysts and drugless practitioners appear to pose a limited threat to public safety, or seem to be obsolete or vestigial.

ISSUE #3. Should any new or additional license classifications be regulated by the Board?

Recommendation: ***Both the Department and Committee staff recommended, that prior to the creation of any new health practitioner licensure category (e.g., naturopaths, homeopaths, perfusionists, etc.), proponents should still be required to meet the mandates of Section 9148 et seq. of the Government Code. (This is a "sunrise process" similar to the current sunset review process of this Committee.) This law enables the Legislature, the Medical Board, health care professions, and other health care-related licensing boards, to properly evaluate the regulatory proposal's merits, potential overlap with other health professions, and the appropriate administrative location within an existing agency, or the need for a newly created licensing agency.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: During every Legislative Session, legislation is introduced to regulate a new or additional category of health care professional. Often these proposals are not carefully substantiated, or represent only a very small number of potential practitioners. This results in discussion over whether there is a need to regulate this particular professional group, and the appropriate location for this new licensure program within an existing agency, or the need to create a separate regulatory board or committee. The current law, Section 9148 et seq. of the Government Code, and the rules of the Senate Business and Professions Committee, require proponents of such proposals to go through a "sunrise" process, similar to the sunset review process, where proponents of the new licensure program must provide justification and substantiation for the new licensure classification. This enables the Legislature to determine the public need for such a regulatory program, and the degree of regulation necessary. It also enables any affected persons and related occupational groups to carefully assess the impact of the proposal prior to consideration in the legislative process, so that Legislators can be provided with a thorough and balanced evaluation.

ISSUE #4. Should an independent Medical Board of California be retained as the state's licensing agency for physicians, and the other directly regulated health professions, or should its operations and functions be assumed by the Department of Consumer Affairs?

Recommendation: ***Both the Department and Committee staff recommended that the Medical Board of California should be retained with its current authority to license and regulate physicians, and the other health care practitioners it directly licenses and regulates. Committee staff recommended that the sunset date of the Medical Board be extended for four years, to July 1, 2003.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: In the past six years, prompted by significant legislative changes in the medical practice act and related disciplinary laws, and the appointment of new Board members and management staff, the Board has improved its performance. This has even been noted by the Public Citizen's Health Research Group in its comparative ratings of state medical Boards based on their disciplinary efforts (California was ranked 27th by the Group in 1996.) The Board has made a number of structural and procedural changes in the way it performs its disciplinary function including: establishing a 10-point plan for improving its disciplinary operation, centralizing all complaint intake through its Central Complaint Unit, establishing a list of medical expert reviewers, working more closely with a special Health Quality Enforcement Section of attorneys at the Attorney General's Office (AG) and with specially trained administrative law judges at the Office of Administrative Hearings (OAH) for hearing its cases.

The Board reported a significant increase in the number of complaints filed (from 6,730 in 92/93 to over 10,000 in 96/97). With over 65% being resolved informally (without the need for investigation or further disciplinary action) by the Board's Central Complaint Unit. During the same period, the Complaint Unit's processing time was reduced from an average of 142 days to 64 days. The number of formal investigations commenced by the Board, during that same four year period, has remained at around 2,000; with the number of cases referred to the AG going from 607 to 567. The number of accusations filed by the AG, on behalf of the Board, has remained about the same (304 filed during FY

1992/93 and 296 filed in 1996/97). However, from FY 93/94, the AG has reduced the time it takes to file an accusation from 274 days to 139 days, on average; and the AG reports that its pilot program, of having deputy AG's spend time working in some of the Board's district offices, has resulted in average accusation filing times of less than 30 days. Disciplinary action taken against licensees by the Board doubled from 149 in FY 92/93 to 340 by
FY 96/97.

However, the amount of time it takes to discipline a licensee still appears to take a very long time in many cases. Enacted in 1990, Section 2319 of B&P Code set a legislative goal of 6 months for the Board to process complaints and investigate cases, or up to 1 year for more complex cases. Cases are still taking, on average, about 13 months to process and investigate, and almost 3 years on average to prosecute to a final disposition. There also appears to be some dissatisfaction with those who file complaints with the Medical Board. Based on the results of survey which was requested by the Joint Committee, about 60% of complainants responding to the survey indicated a high dissatisfaction with overall service provided by Board. Also, the Board is projecting having a fund deficit in several years. For these reasons, and to assure continued improvement in the enforcement program, the Board should be reviewed in four years.

ISSUE #5. Should the size or composition of the Medical Board be changed?

Recommendation: ***This Board has 19 members, of which 12 are licensed physicians and 7 are public members. The Board's Division of Medical Quality has 12 members, of which 8 are physicians and 4 are public members(a two-to-one majority). The Department generally recommends a public member majority and an odd number of members for regulatory boards. For the Medical Board, the Department recommended an increase in public membership to improve balance consistent with those guidelines. Committee staff concurred in part with the Department, but recommended removing two of the physician members to provide better balance between professional and public members, rather than increasing the overall size of the Board. The composition of the Board would be 17 members, with
10 physicians and 7 public members. The Division of Medical Quality should also be correspondingly changed to include 10 members, with
6 physicians and 4 public members.***

Vote: ***The Joint Committee did not adopt the recommendation of the Department and Committee staff. Although the vote to adopt the recommendation was 4-1, it lacked a majority of Assembly members.***

Comment: At 19 members, the Board is the largest licensing Board in the Department. Currently, physicians have almost a two to one super-majority on the Board, and its disciplinary Division of Medical Quality. The Department generally recommends having a public member majority and an odd number of members on occupational regulatory Boards, or at least achieving greater representation of the public, where current Board composition is heavily weighted in favor of the profession. The Center for Public Interest Law (CPIL), which for years has evaluated the performance of California's licensing Boards, and specifically that of the Medical Board, has espoused similar views. CPIL has argued that such a change would alter both the public's perception of self-serving control and improve the Board's performance in the public's interest. Prior legislation, to make the majority of the Board public members, failed during the 1995/96 Legislative Session, due to opposition that cited the lack of evidence that medical boards with larger public representation performed better than California Medical Board.

Since the Board's primary purpose is to protect the public - and there have been problems in the past, and continue to be problems, with the public's perception of the Board in performing its consumer protection role - providing better balance between the professional and public membership on the Board, could serve the purpose of assuring the public that the profession's interests do not outweigh that of the Board's in protecting the public from incompetent, negligent, or unlawful activity on the part of licensees. This is especially true for the Division of Medical Quality which is responsible for the enforcement of the disciplinary and criminal provisions of the Medical Practice Act, and making decisions concerning disciplinary actions against licensees of the Board. The Division currently has 12 members, with 8 physicians and 4 public members, a two-to-one majority. This Divisions is also divided into two panels to review disciplinary cases. Each panel has
4 physicians and 2 public members. Removing two physicians from the Division would provide better balance of public representation on these panels.

ISSUE #6. Should the Board retain its existing jurisdiction over the other affiliated health professional licensing boards and committees, which are currently within the jurisdiction and control of the Board?

Recommendation: ***The Department did not address this issue. Committee staff recommended placing a sunset date of two years (July 1, 2000) on the jurisdiction of the Board over the following affiliated health practitioners boards and committees: Acupuncture Committee, Hearing Aid Dispensers Examining Committee, Speech, Language Pathology and Audiology Examining Committee, Board of Psychology, Respiratory Care Board, and the Physical Therapy Examining Committee. In the meantime, the Board should provide evidence of the continued need to have jurisdiction over these boards and committees.***

Vote: ***The Joint Committee adopted the recommendation of Committee staff by a vote of 6-0.***

Comment: In addition to those affiliated health professions directly regulated by the Medical Board itself, there are eight affiliated health practitioner boards or committees within the jurisdiction of the Medical Board: Acupuncture Committee, Hearing Aid Dispensers Examining Committee, Physical Therapy Examining Committee, Physician Assistant Examining Committee, Board of Podiatric Medicine, Board of Psychology, Respiratory Care Board, and the Speech, Language Pathology and Audiology Examining Committee.

In some cases (e.g., Acupuncture Committee), the Board's jurisdiction appears very limited and essentially vestigial. Absent a particular operational need or interest on the part of any of those licensing agencies, or their licensees, that would make such Medical Board jurisdiction useful, it seems that at least some could function well as totally autonomous agencies. Also, reducing the administrative effort required for the Medical Board, to exercise its often minimal jurisdiction over affiliated healing arts professions, could free up the Board's limited resources to concentrate on its primary regulatory efforts regarding licensed physicians.

Exceptions may be the Physician Assistant Examining Committee, because of the close supervisory relationship by physicians over physician assistants and the significant administrative role currently exercised by the Medical Board; and the Board of Podiatric Medicine - whose licensees are subject to many of the same provisions of the medical practice laws as physicians.

ISSUE #7. Should the Medical Board make any changes regarding the qualifications or use of its "medical expert reviewers" in its enforcement process? In particular, should physicians who practice using eclectic or alternative medical modalities be included for case review involving those modalities?

Recommendation: ***No recommendation at this time. There was insufficient evidence to recommend any changes in the use of "medical expert reviewers" by the Medical Board, or that physicians who practice eclectic or alternative medical modalities must be included as medical expert reviewers for enforcement cases involving those modalities.***

Comment: The Medical Board has established a program to recruit well-qualified medical experts representing various practice specialties to review the medical practices of physicians in disciplinary cases involving quality of medical care. These experts are selected after careful initial screening for qualifications, and ongoing review of their performance in case reviews and testimony at disciplinary hearings. They are paid on an hourly rate basis by the Board for their services.

Criticisms have been made that the experts selected by the Board do not adequately represent all practice specialties and that they are not adequately trained in particular medical practice modalities - leading to concerns that some acceptable treatment modalities are unfairly treated in a prejudicial manner. The Professional Advocacy Network (PAN) has recommended that the Board's experts include physicians who practice alternative medical modalities - so that cases involving such practices by physicians will be reviewed by peers who are expert in those non-traditional, non-allopathic treatment modalities.

Another criticism from PAN, is that medical expert reviewers are also pressured the Board's enforcement program to make negative evaluations of a physician's performance - so that the Board's enforcement efforts can proceed. It is argued, primarily by PAN, that the Board's enforcement program has a strong negative ("guilty until proven innocent") bias, and that expert medical reviewers whose evaluations are not in keeping with this viewpoint are not retained in the future by the Board to perform (and be paid for) their evaluations.

ISSUE #8. Should the Board make any changes in its current enforcement program in order to eliminate unnecessary or excessive delays and improve the quality of its disciplinary process?

Recommendations: ***The Department did not address this issue. Committee staff recommended that the Board take the following steps to improve its enforcement program:***

1. Expansion of its program to place deputy AGs in all of the Board's 12 district offices to speed up and improve its enforcement efforts - particularly the prosecutorial review of investigations and the filing of administrative accusations.

2. Altering the legal requirements or procedures, and/or increasing the penalties for non-compliance with Board subpoenas to obtain medical records from physicians and health facilities and for failure to comply with the various reporting requirements in the law - particularly those relating to peer review actions regarding staff or practice privileges at health facilities.

3. Improving the Board's capability (especially computer system) to effectively document data relevant to the Board's specific enforcement functions, particularly the activities performed and the amount of time expended at each stage of the disciplinary process, the specific costs related thereto, the difficulties encountered in pursuing effective discipline, and the disciplinary outcomes relative to various types of violations.

4. Take steps to eliminate the endemic vacancies in the Board's investigator positions, particularly in the Los Angeles area.

Vote: ***The Joint Committee adopted the recommendation of Committee staff by a vote of 6-0.***

Comment: The Board has made significant efforts in recent years to streamline and speed up its enforcement process. However, despite increasing centralization, automation, and elimination of unnecessary or redundant activities, and other efficiencies, it continues to experience significant investigative and prosecutorial delays, and high costs due to the increase in hourly charges by the Attorney General's Office (AG) - a separate agency upon whom it must rely for prosecution of its disciplinary cases, and with whom it must expend a great deal of effort in coordination.

Among the significant problems cited by the Board as impeding its disciplinary efforts are: increased/excessive caseload on investigative personnel, a high investigator vacancy rate - particularly in the Los Angeles area (with four district offices), increasing legal resistance to compliance with the Board's request for patient's medical records from physicians and health facilities, difficulty in obtaining Section 805 peer review action reports concerning physicians, a high standard of proof in administrative actions (clear and convincing to a reasonable certainty - rather than preponderance of the evidence.)

The Board has also noted that its current computer automation system for documenting and evaluating its enforcement efforts, the CAS system, operated by the Department of Consumer Affairs, is woefully inadequate to meet its needs (and those of other licensing agencies within the department). Given Year 2000 conversion problems and the inherent deficiencies in the CAS system - the Department is proposing to replace current systems within two years with a new proprietary computer system, the ICPS, that will combine both licensure and enforcement information and assure greater efficiency in processing and tracking complaints and disciplinary actions.

ISSUE #9. Should a procedure be considered to immediately suspend a licensee's practice, prior to any administrative or court hearing, where there is a clear indication that egregious violations or harm may result to patients unless immediate action is taken?

Recommendation: ***The Department recommended a reexamination of the current process which authorizes the Board to issue interim suspension orders -- with a view toward identifying changes that may simplify and expedite interim suspension orders, consistent with due process, where potential patient harm is imminent. Committee staff concurred with this recommendation, but also recommended that a procedure be considered, as a pilot project, to allow the Medical Board to immediately suspend a physician's license where there is a clear indication that potential patient harm is imminent.***

Vote: ***The Joint Committee adopted the recommendation of the Department and Committee staff by a vote of 6-0.***

Comment: The Board has been considering the possibility of obtaining summary suspension authority in cases of egregious alleged violations of the law or where there is a dire threat to patient safety. This is referred to as "single signature authority," because such summary suspension authority would be granted to the Executive Director without the necessity of a prior administrative judicial or court order following a hearing. A variation of this, would be to further require that the Executive Director also obtain the concurrence of the Board's President prior to proceeding with the suspension (a "dual signature authority").

The Board has indicated that there would be very few instances where such authority would be used, but in cases where it is used, time is of the essence in removing a dangerous physician immediately from practice. It is argued that the current administrative Interim Suspension Order (ISO) or the judicial Temporary Restraining Order (TRO) are too time consuming and costly in these few circumstances. (The Board has been more successful in obtaining ISOs over the past few years, but seeks and obtains them in only a relatively few cases -
37 granted in FY 96/97.)

Joint Committee staff believes that such authority already does exist in at least one case - authority of the Department of Health Services to suspend the license of certain health facilities. However, given its departure from the usual prior administrative or judicial approval by an administrative or judicial judge, and the few circumstances in which it would be employed, it is important that the procedure and grounds for its use be very specifically described. Committee staff recommend that a proposal be drafted, to be reviewed by the Board and the profession, to allow the Board to immediately suspend a physicians license, if there is good evidence that allowing them to continue their practice could potentially cause harm to the public. This procedure should be considered as a pilot project (with a sunset date), which would allow the Board to collect data on the effectiveness or need for this authority and report to the Legislature.

ISSUE #10. Should the Board continue to maintain and operate its own diversion program for physicians impaired by alcohol or drug addiction or mental disease? If so, should this program be expanded to include additional categories of problems or legal violations?

Recommendation: ***The Department recommended that the Medical Board, the Department, other boards with diversion programs, and the Legislature research an appropriate approach to privatizing diversion programs with special attention to the existing participants. Committee staff concurred with this recommendation and recommended that the Medical Board, in conjunction with other boards providing diversion programs, report to the Joint Committee by September 1, 1999, on a plan to privatize diversion programs.***

Vote: ***The Joint Committee did not adopt the recommendation of the Department and Committee staff. The vote was 3-3.***

Comment: California appears to be one of only two state medical Boards that operate its own diversion program. (With a total of about 10 states having any form of officially sanctioned diversion program.) The costs of California's diversion program have been steadily increasing, up to $786,000 for FY 96/97, yet the success rate has been decreasing, down to 16% of those who participated in FY 96/97. Since the inception of the program in 1980, there have been about 800 participants, with 564 (69%) successfully completing the program - which requires two or three years of counseling and an alcohol or drug free rehabilitated lifestyle. Of the 564 "successful" participants, as of December 31,

1996, 38 participants (or 6.7%) have re-entered the diversion program. The Board reports that there were about 213 active participants in its diversion program in FY 96/97, with 35 physicians successful completing the program during that fiscal year, and 21 unsuccessfully leaving the program. The Board notes that a 1991 study indicated that participants who successfully complete the program had fewer complaints (4%) than the average for all licensed physicians (7%).

Participants pay $235 per month to participate in twice-weekly group counseling sessions and also pay an additional $43 for two urine tests conducted each month. The Board argues, that the benefits of the program are in providing rehabilitation to the impaired physician while protecting the public from harm, all at a cost far less than what it might otherwise take to discipline the physician for a violation.

Criticisms of the program include: (1) that it unreasonably diverts physicians from the Board's disciplinary process; (2) that it should not be operated by the Board, but instead by an entity in the private sector separated from the Board (reducing the licensees fear of disciplinary action thereby); (3) conflict of interest on the part of program staff (e.g., group counselors) who are paid $235/mo. by participants (allegedly encouraging participant retention despite violations of the conditions of program participation); and, (4) the inability of the program to actually monitor a participating physician's compliance with agreed-to practice restrictions or cessation.

Given the Board's projected deficit in several years, its increasing enforcement costs, the high cost to the Board to operate this program (about $800,000 out of a budget of $31 million), the relatively low number of program participants (particularly compared to the likely number of impaired physicians generally), and the "success" rates -- it is questionable whether the Board should continue to operate this program.

ISSUE #11. Should the Medical Board be authorized to increase its licensing fees in order to counter the prospect of a fund deficiency in future years?

Recommendation: ***The Department did not address this issue. Based on information provided by the Board, Committee staff recommended that a fee increase be considered, but only after providing appropriate justification to the standing and appropriation committees of the Legislature. The Board should also consider whether the following would be feasible ways of reducing its costs: privatizing its diversion program, having its diversion program participants pay for more of the Board's costs of that diversion, using employees, other than costly investigators, to monitor its probationers, or having probationers reimburse the Board for more of its probation monitoring costs. Any fee increase should be used for purposes of improving the Board's enforcement program.***

Vote: ***The Joint Committee did not adopt the recommendation of Committee staff. The vote was 2-3.***

Comment: In the face of increasing costs, particularly for its enforcement operations, the Board has recommended seeking legislative authority to increase the ceiling on its license fees. The current biennial license fee for physicians is $600 ($300/yr.) - which limit has been in effect for several years. The Board is projecting that its revenues will not be sufficient to maintain a positive fund condition in about two to three years - at which point it will face a deficit. In the past, the California Medical Association has opposed such fee increases, arguing that the Board could decrease its costs through increased efficiencies rather than increasing its revenues.

This issue is still controversial and the subject of ongoing discussions between the Board and the CMA. The Board expends almost $800,000 on its diversion program and over $800,000 on the costs of its disciplinary probation monitoring efforts. These may be areas where increased cost savings might be possible (e.g., from reimbursement by licensees.) Additionally, the Board may be able to generate additional needed revenue from increased disciplinary cost recovery and increased administrative citations and fines.

The Board has been under public and Legislative pressure for several years to improve the timeliness and efficacy of its disciplinary enforcement program. Its efforts to improve this area of Board operation in the past and in the future have and will generate increased costs for investigative and prosecutorial personnel. Also, the Board is facing almost a $900,000 expenditure next fiscal year (FY 98/99) in order to pay its share to participate in the Department of Consumer Affairs' new ICPS data processing system for licensing and disciplinary operations. Given these increased costs, it appears likely that potential cost savings will be insufficient to offset them completely.

The Board is considering increasing the statutory maximum to $690; a fee increase in effect of $90 on a biennial renewal basis. The Board indicates that this would enable them to hire more investigators and reduce overall time of processing investigations, and make other improvements in the enforcement program. This fee increase would carry them through the next five years. It should be noted, that although the statutory maximum may be raised by the Legislature, the Board would still be required to go through the regulatory process to increase the fee which would require public comment and hearing.

ISSUE #12. Should the educational requirements for initial licensure as a physician be increased, such as adding an additional postgraduate year of training?

Recommendation: ***The Department did not address this issue. Committee staff found no justification for increasing the amount of postgraduate training from one to two years as a prerequisite to licensure, and recommended against a two year requirement for postgraduate training.***

Vote: ***The Joint Committee adopted the recommendation of Committee staff by a vote of 6-0.***

Comment: Both during the current and prior Legislative Sessions, legislation has been introduced to increase the amount of postgraduate training from one to two years as a prerequisite to licensure. It has been argued that a number of other states already have the two year postgraduate training requirement, and that medicine has become increasingly complex necessitating additional training to assure even minimum professional competence. However, there has not been any documentation that the additional training does, or would reduce the occurrences of medical incompetence, or that there is a correlation to physicians who end up being the subject of disciplinary action for incompetent practice, malpractice or peer review actions. The Board notes that most licensed physicians actually obtain more than the minimum one year of postgraduate training.

Increasing the postgraduate training requirement would increase the "barrier to entry" into the medical profession for new license applicants, possibly delay their ability to begin their practice, and delay them from beginning their earning a livelihood from which to pay off the high costs of their medical education.

ISSUE #13. Should the oral examination required for the initial licensure of some applicants be retained?

Recommendation: ***The Department withheld final recommendation concerning the oral exam pending a review by the Medical Board of the appropriateness of the mandatory oral examination for licensure. The Board recently completed its review, and recommended replacing the oral exam with new alternatives for qualifying out-of-state and foreign graduate applicants. Therefore, Committee staff concurred with the recommendation of the Board to eliminate the oral exam. However, Committee staff also recommended that any alternatives proposed to substitute for the oral examination should be no more restrictive than current requirements for California's candidates for licensure.***

Vote: ***The Joint Committee adopted the recommendation of the Board and Committee staff by a vote of 6-0.***

Comment: Currently, the Board requires passage of an oral examination conducted by three licensed physicians for graduates of foreign medical schools and license applicants who are licensed by, and have practiced in, other states for a number of years, and who have not recently taken one of the specified approved national medical licensing examinations. This oral examination asks the applicant to respond to several patient scenarios to ascertain whether the license applicant has the requisite understanding of general medicine, including proper diagnosis and appropriate treatment. This type of examination is also required of licensees who are reapplying for licensure after allowing their licenses to expire after five years of non-renewal.

The Board recently evaluated the efficacy of this form of test, and what other alternatives exist, that might be less costly and time consuming to the Board, and better serve the same purpose of testing basic medical educational competency. It was the recommendation of the Board, that the oral examination be eliminated and replaced with other alternatives to assess the applicants readiness for the unsupervised practice of medicine. Joint Committee staff have not had an opportunity to review other alternatives being proposed to substitute for the oral examination. However, any alternatives proposed should not be more restrictive than current requirements for California's candidates for licensure.

ISSUE #14. Should changes be made to the administrative procedures currently followed by the Board to conduct and prosecute disciplinary enforcement actions against licensees?

Recommendation: ***No recommendation at this time. There was insufficient evidence to recommend any changes to the current administrative procedures followed by the Medical Board in investigating and prosecuting enforcement actions against licensees.***

Comment: The Professional Advocacy Network (PAN) has argued that the current administrative disciplinary structure for physicians and others, particularly the procedures and limitations provided for in California's Administrative Procedure Act (APA), are unconstitutional and unfair to physicians accused of violating the practice laws. In particular, PAN argues against the authority of a licensing Board to overturn ("nonadopt") the decision of an administrative law judge, and supported SB 1212, Vasconcellos in 1997 to enact such a change. That bill was vetoed by the Governor and was opposed by the Department of Consumer Affairs, the AG, and licensing Boards. Further, PAN argues that the current procedures fail to provide the same due process rights to licensees by not giving licensees notice of the complaint or their accusers, and the lack of any statute of limitation on the age of the alleged violative acts which can be prosecuted.

PAN further argues that the Board's investigators, medical experts, and deputy AGs unduly target practitioners of alternative therapies, over zealously seek to impose the harshest penalty possible regardless of the circumstances, and ignore the existence of expert witnesses in support of the accused licensee or mitigating information. PAN argues that the current system of publicizing any formal disciplinary action, including minor discipline such as Letters of Reprimand, unreasonably destroys the livelihoods and lives of innocent licensees or those whose offenses are minor, and whose errors could otherwise have been corrected or rehabilitated through non-public mediation or counseling efforts by the Board.

Licensees have the right to appeal an administrative disciplinary decision to the courts, via a Writ of Mandate to Superior Court - which holds a *de novo* hearing of the entire case. Thereafter the licensee can appeal the Superior Court decision to the Court of Appeal and the Supreme Court. In the 1995/96 Legislative Session, a number of changes were enacted to the APA to provide greater rights and protections to accused licensees. These additional rights and protections were opposed by the AG and others as unreasonably increasing the complexity, difficulty, costs and time that would be necessary for a state agency to successfully pursue disciplinary action against a licensee. However, PAN argues that the expense involved in defending oneself in an administrative hearing, and the high costs involved in pursuing judicial relief effectively preclude licensees from being able to exercise their legal rights in the face of a powerful and well-funded state licensing Board.

It should be noted, that increasing the rights and procedural protections available to defendant licensees in administrative actions will likely increase the costs and the amount of time such administrative adjudication will require. Doing so runs at cross purposes to the object to have speedier or less costly disciplinary action by licensing Boards such as the Medical Board. While due process considerations are important to maintain, changes to the APA, that are not constitutionally required, should be evaluated in light of the foregoing effects. Further, California appears to be the only state where a licensee has the right to a complete *de novo* review of an administrative disciplinary decision which would be subject to the more limited "substantial evidence" available elsewhere.

It is interesting to note, that while most state licensure laws and proposals are based on the premise that the state must intrude into the marketplace to provide the public with necessary protections, by establishing such licensure the state is viewed as creating a property right in the licensees. This new property right for licensees requires an additional and essentially substitute layer of administrative enforcement and due process protections. At times, it seems as if such licensure generates more of the latter administrative burdens to the detriment of the former goal of public protection.

ISSUE #15. Should California enact "health freedom" amendments to its medical practice law to permit physicians to use non-traditional, experimental, or alternative medical modalities, without being subject to disciplinary action, where there is no harm to and informed consent by patients?

Recommendation: ***The Department did not address this issue. Committee staff recommended that the Medical Board continue its efforts to stay current on the changing and emerging treatment modalities in medicine, including those associated with "alternative medicine," to assure that inappropriate disciplinary actions against those using alternative therapies do not occur. It was also recommended that the Board make recommendations to the Legislature on ways to assure the appropriate regulatory oversight of those involved in non-traditional, experimental, or alternative medical modalities.***

Vote: ***The Joint Committee adopted the recommendations of Committee staff by a vote of 6-0.***

Comment: Several states, including New York, Oregon, and Washington, have enacted so-called "health freedom" amendments to their medical practice laws. There are some who advocate enactment of similar amendments to California's law. Generally, such amendments would preclude disciplinary action against a licensed physician (or other health professional) primarily, or solely, because of the use of experimental, non-traditional or alternative medical treatments (e.g., chelation therapy for vascular disease, homeopathy, naturopathy, nutritional supplementation, etc.) - that may not generally be accepted by the majority of physicians (allopathic physicians). Generally these laws would require the treatment to be performed by licensed physicians or health practitioners, require some documentation of efficacy and safety, require prior written disclosure to patients and their written consent, the expectation of potential efficacy in a particular case, and the lack of any patient harm from their use.

The Medical Board held a symposium on "Alternative Medicine" this past August to review the current trends in the acceptance of alternative medicine. There has been a long history concerning the efficacy of alternative medical treatment modalities, what constitutes medical "quackery," and the increasing popularity and use of alternative therapies by the public. Several years ago, former Senator Robert Presley introduced a "health freedom" bill. That bill died in the Senate Business and Professions Committee in the face of strong opposition from the Medical Board, the Attorney General, and the California Medical Association - who argued that it would seriously undermine the ability to prosecute medical charlatans and quacks who use unproven and ineffective treatments to the detriment of their patients and their patient's families.

Recently the Board refused, on a tie vote, the recommendation of the AG to prohibit the off-label (unapproved by the FDA) use of EDTA in chelation therapy for vascular disease. Some approved medical schools are now including coursework on such alternative treatment modalities in their medical curricula. However, the vast majority of licensed physicians, allopathically trained, generally find that such treatments do not meet the normally accepted standard of proper medical care. At the core is a difference in essential philosophy regarding efficacious treatment - similar to the one that apparently led to the licensure of chiropractors in California in 1922 by Initiative.

Given the increased popularity and use of alternative medicine by the public, the recent Board symposium seems timely. Given the potential for alternative medicine to come up in a disciplinary case, it seems reasonable that the Board stay current on the changes and accepted treatment modalities in medicine. It seems that alternative medicine will increase in popularity, and that the history of medicine has examples where treatments that are treated as heretical, later become part of the mainstream of acceptable practice. The acceptability of such unconventional treatments, as meeting the standard of proper medical care, is a critical determination to be made in the disciplinary process. Ultimately, whether the Medical Board can, or should regulate individuals practicing such disparate schools of medical thought such as naturopathy is an issue - if such treatments are to be permitted. However, as with chiropractic or acupuncture, practitioners of different treatment modalities, that are authorized by law, may be better regulated by a separate entity.